STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155524	A. BUILDING 01 B. WING	09/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GLENBURN HOME	618 W GLENBURN ROAD LINTON, IN 47441

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/10/15 Facility Number: 000230 Provider Number: 155524 AIM Number: 100275000 At this Life Safety Code survey, Health Center At Glenburn Home was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and resident sleeping rooms in the 400 north hall, 500 north hall, 600 hall, and 700 hall, and 700 rehabilitation	K 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective September 28, 2015 to the state findings of the Life Safety Code Recertification and State Licensure Survey conducted on September 10, 2015.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	suite rooms, plus battery operated smoke detectors in the 300 south hall, 400 south hall, 500 south hall and all Special Care Unit resident sleeping rooms, including the 100 and 200 halls. The facility has a capacity of 149 and had a census of 130 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except an attached structure used as a maintenance shop and storage room separated from the facility by a two hour fire wall, and one detached garage used for facility storage. Quality Review completed 09/15/15 - DA			
K 0018 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.			

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	Based on observation and interview, the facility failed to ensure 1 of 1 sets of double doors to the corridor were equipped with positive latches and latched into the door frame. This deficient practice could affect any number of residents, as well as staff and visitors while in the Friendly Grove Hall and adjoining halls which pass through this area. Findings include: Based on observation on 09/10/15 at 12:15 p.m. during a tour of the facility with Maintenance Supervisor, the set of double doors to the Friendly Grove Hall clean linen closet were sliding doors which did not latch into the door frame. This was acknowledged by Maintenance Supervisor at the time of observation. 3.1-19(b)	K 0018	The corrective action taken for those residents found tobe affected by the deficient practice is that the sliding double doors identified duringthe survey on the linen closet of the Friendly Grove Unit have been replacedwith framed positive latched doors. The corrective action taken for the other residents havingthe potential to be affected by the same deficient practice is that a housewide audit has been completed by themaintenance director to determine if there are any other doors that do not meetthis requirement. No other doors wereidentified. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for themaintenance department staff on the regulation related to acceptable standardsrelated to doors protecting corridor openings requiring positive door latches. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by* a Quality Assurance tool has been developedand implemented to monitor the type of doors that are used to protect corridoropenings to	09/29/2015

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			ensure that they meet life safety code standards. This tool will be completed by theMaintenance Supervisor and/or his designee. The tool will be completed weekly for four weeks, then monthly for twomonths and then quarterly for three quarters. The outcomes will be reviewed at the facility's Quarterly QualityAssurance meeting to determine if any additional action is warranted.	

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K 0144 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure 2 of 2 emergency generators was inspected and	K 0144	1).The corrective action taken for those residents foundto be affected by the deficient practice is that allresidents have the potential to be	09/29/2015

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	exercised in accordance with NFPA 99. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's Emergency Generator monthly testing log on 09/10/15 at 10:45 a.m. with the Maintenance Supervisor present, the generator log form documented both generators were tested monthly for 30 minutes under load, however, there was no documentation on the form that showed both generators had cool down times following their load tests. During an interview at the time of record review, the Maintenance Supervisor confirmed the monthly generator log did not include documentation of the cool down times being recorded. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 2 emergency generators providing power to		affected. The facility is now documenting weekly that each of the facilities twogenerators are being inspected. The log also reflects that each generator isexercised under load for 30 minutes each month. There is also documentation supporting that the cool down times arerecorded on the Emergency Generator Manual Load Test Log. 2).The corrective action taken for those residents foundto be affected by the deficient practice is that allresidents have the potential to be affected by this deficient practice. The facility is now documenting that eachemergency generator that provides power to the emergency lighting system isexercised under operating temperature conditions at not less than 30 percent ofthe EPS (Emergency Power Supply) name plate rating monthly for a minimum of 30minutes. The corrective action taken for the other residents havingthe potential to be affected by the same deficient practice is that the facility has revised the log for the EmergencyGenerator Manual Load Test. The log nowincludes that each of the facilities two generators are being inspected weeklyand that each generator is exercised under load for 30 minutes each month. There is also documentation included toreflect the cool down times	

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	the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's Emergency Generator monthly testing log on 09/10/15 at 10:45 p.m. with the Maintenance Supervisor present, the generator log form documented the south generator was tested monthly under load, however, the documentation did not show the generator was exercised under operating temperature conditions or at not less than 30 percent of the EPS		following each generators monthly load test. The log also includes documentation that eachgenerator was exercised under operating temperature conditions or at not lessthan 30 % of the EPS (Emergency Power Supply) nameplate rating for a minimum of30 minutes each month. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that the facility has conducted a mandatory in-service forthe maintenance department staff on the changes to the emergency generator logand their responsibility in the completion of the log weekly. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by* the submission of the completed EmergencyGenerator Manual Load Test logs to the Quarterly Quality Assurance meeting forreview. Additional action will beimplemented as deemed warranted by the Quality Assurance Committee. This will be an on-going process.	

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	(Emergency Power Supply) nameplate rating for a minimum of 30 minutes during the past twelve months and was under the 30 percent requirement. The generator log form indicated the south generator was load tested at 28 % which did not meet the 30 percent requirement. This was acknowledged by the Maintenance Supervisor at the time of record review. 3.1-19(b)			

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